		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 W. ANTLE (Number) PETERSBURG (City) 62675 (Zip Code)

County: MENARD

Telephone Number: 217-632-2249 **Fax #** 217-632-2314

IDPA ID Number: 37-0856151001

Date of Initial License for Current Owners: 12/1/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217-787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/03 to 11/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	59	Skilled (SNF)	59	21,594	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,882	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,476	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,456	3,456	8
9	SNF/PED					9
10	ICF	11,268	4,296		15,564	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,268	4,296	3,456	19,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.43%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / / 66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 3,456

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/04 Fiscal Year: 11/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	95,529	10,151	4,787	110,467		110,467		110,467			1
2	Food Purchase		69,515		69,515		69,515	(2,804)	66,711			2
3	Housekeeping	39,336	9,719		49,055		49,055		49,055			3
4	Laundry	26,313	8,003		34,316		34,316		34,316			4
5	Heat and Other Utilities			52,464	52,464		52,464		52,464			5
6	Maintenance	27,977	20,650	30,245	78,872		78,872	832	79,704			6
7	Other (specify):*	12,674			12,674		12,674		12,674			7
8	**TOTAL General Services**	201,829	118,038	87,496	407,363		407,363	(1,972)	405,391			8
	B. Health Care and Programs											
9	Medical Director	12,087		14,400	26,487		26,487		26,487			9
10	Nursing and Medical Records	817,743	183,781	74,090	1,075,614	(150,774)	924,840	5,710	930,550			10
10a	Therapy	20,799	602	182,876	204,277	(182,876)	21,401		21,401			10a
11	Activities	38,063	3,284		41,347		41,347		41,347			11
12	Social Services	6,413		4,127	10,540		10,540		10,540			12
13	Nurse Aide Training	704		1,086	1,790		1,790		1,790			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	895,809	187,667	276,579	1,360,055	(333,650)	1,026,405	5,710	1,032,115			16
	C. General Administration											
17	Administrative	50,000		11,154	61,154	2,520	63,674	28,877	92,551			17
18	Directors Fees											18
19	Professional Services			109,733	109,733		109,733	(100,738)	8,995			19
20	Dues, Fees, Subscriptions & Promotions			24,329	24,329		24,329	(17,783)	6,546			20
21	Clerical & General Office Expenses	41,701	13,957	5,618	61,276		61,276	20,773	82,049			21
22	Employee Benefits & Payroll Taxes			204,690	204,690		204,690	13,007	217,697			22
23	Inservice Training & Education			2,445	2,445		2,445	1,501	3,946			23
24	Travel and Seminar			4,686	4,686	(3,706)	980	377	1,357			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,072	67,072		67,072	288	67,360			26
27	Other (specify):*			15,732	15,732		15,732	(15,732)				27
28	**TOTAL General Administration**	91,701	13,957	445,459	551,117	(1,186)	549,931	(69,430)	480,501			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,189,339	319,662	809,534	2,318,535	(334,836)	1,983,699	(65,692)	1,918,007			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,170	18,170		18,170	5,335	23,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,526	27,526		27,526	(198)	27,328			32
33	Real Estate Taxes			14,201	14,201		14,201		14,201			33
34	Rent-Facility & Grounds							3,563	3,563			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			59,897	59,897		59,897	8,700	68,597			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					334,836	334,836		334,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,214	47,214		47,214		47,214			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			47,214	47,214	334,836	382,050		382,050			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,189,339	319,662	916,645	2,425,646		2,425,646	(56,992)	2,368,654			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(900)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,916	30		9
10	Interest and Other Investment Income	(198)	32		10
11	Discounts, Allowances, Rebates & Refunds	(491)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,555)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,797)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,177)	27		24
25	Fund Raising, Advertising and Promotional	(17,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(357)	20		28
29	Other-Attach Schedule VENDING	(1,904)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,948)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,044)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (22,044)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,992)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		182,876	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		12,504	10	42
43	Prescription Drugs	X		117,127	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule IV, OXYGEN	X		21,094	10	45
46	Other-Attach Schedule SUPPLIES	X		1,235	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 334,836		47

STATE OF ILLINOIS

Page 5A

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/03

Ending: 11/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(900)	0	0	0	0	0	0	0	0	0	0	(900)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(900)	0	0	0	0	0	0	0	0	0	0	(900)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	169	0	0	0	0	0	0	0	0	0	169	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,797)	(99,034)	0	0	0	0	0	0	0	0	0	(100,831)	19
20	Fees, Subscriptions & Promotions	(17,842)	0	0	0	0	0	0	0	0	0	0	(17,842)	20
21	Clerical & General Office Expenses	(491)	0	0	0	0	0	0	0	0	0	0	(491)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(169)	0	0	0	0	0	0	0	0	0	(169)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(15,732)	0	0	0	0	0	0	0	0	0	0	(15,732)	27
28	**TOTAL General Administration**	(35,862)	(99,034)	0	0	0	0	0	0	0	0	0	(134,896)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,762)	(99,034)	0	0	0	0	0	0	0	0	0	(135,796)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,916	0	0	0	0	0	0	0	0	0	0	3,916	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(198)	0	0	0	0	0	0	0	0	0	0	(198)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,718	0	0	0	0	0	0	0	0	0	0	3,718	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,044)	(99,034)	0	0	0	0	0	0	0	0	0	(132,078)	45

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	50.00	HILLTOP NURSING HOME	CHARLESTON	NURS. HOME MNGR	SPRINGFIELD	MANAGEMENT
ROBERT SCHAFER	25.00	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE			
BARRY FREE	25.00	MEADOW MANOR	TAYLORVILLE			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 107,638	NURSING HOME MANAGERS		$	$ (107,638)	1
2	V	VAR	SEE ATTACHED		NURSING HOME MANAGERS		76,990	76,990	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,604	8,604	3
4	V	24	TRAVEL	169	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(169)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		169	169	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 107,807			$ 85,763	$ * (22,044)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT SCHAFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		$ 12,087	9-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,087		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS
Street Address: 2653 W. LAWRENCE, SUITE B.
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	SAM KLEIN ESTATE	X		WORKING CAPITAL		5/30/03	25,000	755,000	DEMAND	0.0400	27,526	6
7												7
8												8
9	TOTAL Facility Related						$ 25,000	$ 755,000			$ 27,526	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 25,000	$ 755,000			$ 27,526	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	12,472	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	13,917	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,445	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	12,756	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	14,201	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	13,870	8
	2000	13,705	9
	2001	13,764	10
	2002	13,606	11
	2003	13,917	12

LINE 4 ACCRUAL 11/12 OF $13,917 = $12,756

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-219-009	MENARD CONVALESCENT CENTI	$ 534.30	$ 534.30
2.	11-14-227-001		$ 835.66	$ 835.66
3.	11-14-228-001		$ 11,651.16	$ 11,651.16
4.	11-14-228-002		$ 485.50	$ 485.50
5.	11-14-229-001		$ 311.68	$ 311.68
6.	11-14-219-006		$ 98.20	$ 98.20
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,916.50	$ 13,916.50

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	43,436	1963-1964	$ 9,919	1
2					2
3	TOTALS	43,436		$ 9,919	3

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966	$ 172,985	$ 1,397	30	$	$ (1,397)	$ 172,985	4
5	32		1974	1974	148,705	110	30		(110)	148,705	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1966	5,308					5,308	9
10	FIRE DOORS			1979	1,433					1,433	10
11	FIRE DOORS			1981	8,340					8,340	11
12	BATHROOM			1984	7,335		30	245	245	5,021	12
13	AIR CONDITIONER			1984	1,100		8			1,100	13
14	ELECTRICAL & PLUMBING			1985	11,117	95	15		(95)	11,117	14
15	PLUMBING			1986	4,921	207	15		(207)	4,921	15
16	SMOKE DETECTORS			1986	10,445	439	25	418	(21)	7,732	16
17	AIR CONDITIONER			1986	2,235	94	10		(94)	2,235	17
18	PLUMBING			1986	1,145	48	20	57	9	1,056	18
19	ROOF			1987	6,362	233	20	318	85	5,565	19
20	WATER HEATER & WINDOWS			1988	6,530	207	15		(207)	6,530	20
21	NURSE CALL			1988	1,674	53	10		(53)	1,674	21
22	ROOF			1989	30,672	974	20	1,534	560	23,776	22
23	WATER HEATER & PARKING LOT			1989	11,502	365	15	381	16	11,502	23
24	FURNACE & FLOORING			1990	19,165	608	15	1,278	670	18,530	24
25	AIR CONDITIONER			1991	2,633	83	15	175	92	2,373	25
26	PLUMBING FAUCETS			1992	8,909	283	15	594	311	7,425	26
27	DOOR ALARM			1992	1,572	50	20	79	29	1,103	27
28	WATER HEATER & GARAGE DOOR			1993	4,348	138	15	290	152	3,335	28
29	WATER HEATER & PLUMBING			1994	5,074	130	15	338	208	3,550	29
30	LANDSCAPING			1994	3,900	260	15	260		2,665	30
31	AIR CONDITIONER & ROOF			1995	7,049	181	15	470	289	4,465	31
32	REMODEL BATHROOMS - TILE, CEILING, FIXTURES			1996	19,751	506	15	1,317	811	11,193	32
33	AIR CONDITIONER			1997	1,710	44	15	114	70	855	33
34	FIRE DAMPERS			1998	4,076	105	15	272	167	1,767	34
35	FURNACE			1998	2,200	56	15	147	91	954	35
36	GREASE TRAP			1999	2,824	72	15	188	116	1,035	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CEILING REPAIR	2002	$ 4,935	$ 127	15	$ 329	$ 202	$ 960	37
38	AIR CONDITIONING	2002	2,102	54	15	140	86	303	38
39	AIR CONDITIONING & VENTILATION	2004	4,935	100	10	411	311	411	39
40	WATER HEATER	2004	1,675	2	15	9	7	9	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 528,667	$ 7,021		$ 9,364	$ 2,343	$ 479,933	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 138,890	$ 8,184	$ 11,922	$ 3,738	VAR	$ 92,988	71
72	Current Year Purchases	18,393	2,965	800	(2,165)	VAR	800	72
73	Fully Depreciated Assets	140,921					140,921	73
74	ASSETS NO LONGER IN SERVICE	(73,230)					(73,230)	74
75	TOTALS	$ 224,974	$ 11,149	$ 12,722	$ 1,573		$ 161,479	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 763,560	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,170	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,086	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,916	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 641,412	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 315	$	$ 315
2	Books and Supplies			68		68
3	Classroom Wages	(a)		477		477
4	Clinical Wages	(b)		227		227
5	In-House Trainer Wages	(c)				
6	Transportation			220		220
7	Contractual Payments			433		433
8	Nurse Aide Competency Tests			50		50
9	TOTALS		$	$ 1,790	$	$ 1,790
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,790			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-8	hrs	$	1,582	$ 81,142	$	1,582	$ 81,142	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		363	16,625		363	16,625	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs		1,919	85,109		1,919	85,109	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				117,127		117,127	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen,Supplies, Xray	39-8					34,833		34,833	13
14	TOTAL			$	3,864	$ 182,876	$ 151,960	3,864	$ 334,836	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,661	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	452,539		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,637		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 479,837	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	172,985		14
15	Leasehold Improvements, at Historical Cost	355,682		15
16	Equipment, at Historical Cost	293,750		16
17	Accumulated Depreciation (book methods)	(693,045)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 139,291	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 619,128	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 919,711	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,653		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,099		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,756		32
33	Accrued Interest Payable	2,482		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,037,701	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,037,701	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (418,573)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 619,128	$	48

***(See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (222,109)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (222,109)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(196,464)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (196,464)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (418,573)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,316,562	1
2	Discounts and Allowances for all Levels	(163,802)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,152,760	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	49,772	6
7	Oxygen	17,270	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 67,042	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	198	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 198	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 1904, Expense Reimbursement 900	2,804	28
28a	Adm Fee 405, Bad Debt Recovery 5887, W/A 86	6,378	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,182	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,229,182	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	407,363	31
32	Health Care	1,360,055	32
33	General Administration	551,117	33
	B. Capital Expense		
34	Ownership	59,897	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	47,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,425,646	40
41	**Income before Income Taxes (line 30 minus line 40)****	(196,464)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (196,464)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,120	$ 47,480	$ 22.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,713	4,958	109,813	22.15	3
4	Licensed Practical Nurses	13,172	13,826	229,267	16.58	4
5	Nurse Aides & Orderlies	41,607	43,080	431,183	10.01	5
6	Nurse Aide Trainees	100	100	704	7.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,891	1,996	20,799	10.42	8
9	Activity Director	1,819	1,986	17,586	8.85	9
10	Activity Assistants	2,710	2,830	20,477	7.24	10
11	Social Service Workers	712	767	6,413	8.36	11
12	Dietician					12
13	Food Service Supervisor	1,822	2,078	23,289	11.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,882	9,250	72,240	7.81	15
16	Dishwashers					16
17	Maintenance Workers	3,201	3,366	27,977	8.31	17
18	Housekeepers	5,173	5,258	39,336	7.48	18
19	Laundry	3,326	3,622	26,313	7.26	19
20	Administrator	2,000	2,080	50,000	24.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,236	3,504	41,701	11.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,087	40.29	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) UTILITY	1,945	2,128	12,674	5.96	33
34	TOTAL (lines 1 - 33)	98,729	103,249	$ 1,189,339 *	$ 11.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 4,787	1-3	35
36	Medical Director	100	14,400	9-3	36
37	Medical Records Consultant	18	553	10-3	37
38	Nurse Consultant	512	26,599	10-3	38
39	Pharmacist Consultant	96	2,139	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	40	4,127	12-3	45
46	Other(specify) MEDICARE CONS.	192	26,097	10-3	46
47	URC	5	475	10-3	47
48	ADMINISTRATIVE CONSULTANT	344	11,154	17-3	48
49	TOTAL (lines 35 - 48)	1,450	$ 90,331		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 318	10-3	50
51	Licensed Practical Nurses	510	17,021	10-3	51
52	Nurse Aides	46	888	10-3	52
53	TOTAL (lines 50 - 52)	564	$ 18,227		53

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JULIA SMITH	ADMINISTRATOR		$ 50,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,000

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 11,154
TOTAL (agree to Schedule V, line 17, col. 3)	$ 11,154
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 107,638
CSC	CORP. REPRESENTATION	298
FELDMAN, WASSER, ET AL	LEGAL	1,797
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 109,733

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,538
Unemployment Compensation Insurance	26,839
FICA Taxes	89,997
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	49,917
EMPLOYEE LIFE INSURANCE	2,645
EMPLOYEE GIFT CERTIFICATES	1,260
VACCINES	2,494
NURSING HOME MANAGERS ALLOCATION	13,007
TOTAL (agree to Schedule V, line 22, col.8)	$ 217,697

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
GIFT CERTIFICATES	22	$ 1,260
VACCINES	22	2,494
TOTAL		$ 3,754

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	4,414
Health Care Worker Background Check	578
(Indicate # of checks performed 41)	
PUBLIC RELATIONS	17,485
YELLOW PAGES	357
FOOD & SANITATION LICENSES	185
CLIA LAB FEE	150
FRANCHISE FEES	165
NURS. HOME MNGRS ALLOCATION	59
Less: Public Relations Expense	(17,485)
Non-allowable advertising	( )
Yellow page advertising	(357)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,546

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC MILEAGE REIMBURSEMENT	980
TRANSFER HOME OFFICE TRAVEL	(169)
NURS. HOME MNGRS ALLOCATION	546
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,357

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING	6/90	$ 1,471	3 YR	$	$	$	$	$	$	$	$	$
2	PAINTING	7/91	1,450	3 YR									
3	PAINTING	7/94	2,726	3 YR									
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,647		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MENARD CONVALESCENT CENTER **#** 0003020 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **593** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,214**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V - PAGES 3 & 4

PAGE 3 - LINE 27 - COLUMN 3
OTHER GENERAL ADMINISTRATION

SALES TAX	$ 2,555
BAD DEBT	13,177
	$ 15,732

COLUMN 5 - RECLASSIFICATIONS

RECLASS FROM:		LINE #
IV'S	$ (1,490)	10
X - RAYS	(5,720)	10
LABS	(6,784)	10
MEDICARE DRUGS	(117,127)	10
MEDICARE SUPPLIES	(1,235)	10
OXYGEN	(19,604)	10
PHYSICAL THERAPY	(85,109)	10A
SPEECH THERAPY	(16,625)	10A
OCCUPATIONAL THERAPY	(81,142)	10A
RECLASS TO:		
ANCILLARY	$ 334,836	39
RECLASS TO:		
NURSE CONSULTANT TRAVEL	$ 1,186	10
ADMINISTRATIVE CONS. TRAVEL	2,520	17
RECLASS FROM:		
TRAVEL	$ (3,706)	24

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATIIOI	$ 22,086
NURSING HOME MANAGERS ALLOCATION	1,419
SCHEDULE V - LINE 30 - COLUMN 8	$ 23,505

SCHEDULE XVII - PAGE 19

RECONCILIATION OF INCOME

LINE 41 - NET INCOME	$ (196,464)
* ACCRUED MANAGEMENT FEE 11/03	(5,481)
* ACCRUED MANAGEMENT FEE 11/04	11,935
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(198)
TAXABLE INCOME	$ (190,208)

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTANCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPART WORKED BASED UPON TIME CARDS.

SCHEDULE XIII - PAGE 15

NURSE AIDES TRAINED AT:

SUNRISE MANOR OF VIRDEN
333 S. WRIGHTSMAN
VIRDEN, IL 62690

TMENTS

SCHEDULE VII - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
MENARD
2003

	DEC 03	JAN 04	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2003 TOTAL	LINE #
SALARIES-ADMIN	$2,263	$2,036	$1,997	$2,039	$2,169	$2,303	$2,279	$2,299	$2,400	$2,492	$2,408	$2,390	$27,073	17
SALARIES-CLERIC	1,514	1,409	1,382	1,411	1,501	1,593	1,577	1,591	1,805	1,874	1,811	1,798	19,263	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	226	360	354	361	384	408	403	407	695	722	697	692	5,710	10
ACCOUNTING	(26)	9	8	9	9	10	10	10	14	14	14	14	93	19
WORK COMP INS	2	12	12	12	13	14	13	14	18	18	18	18	163	22
SUPPLIES	53	76	75	76	81	86	85	86	79	82	80	79	938	21
TELEPHONE	78	78	76	78	83	88	87	88	101	105	101	100	1,063	21
EMPL BENEFITS	677	597	586	598	636	676	668	674	1,045	1,085	1,048	1,041	9,332	22
PAYROLL TAXES	206	276	271	277	294	313	309	312	310	322	311	309	3,512	22
TRAVEL	53	39	38	39	41	44	44	44	50	52	51	50	546	24
IN SERVICE	52	83	81	83	88	94	93	94	206	214	207	205	1,501	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	16	38	38	39	41	44	43	43	18	18	18	17	372	6
OWNERS COMP	133	121	118	121	129	136	135	136	150	156	150	149	1,635	17
INS-PROP,LIAB,WC	24	21	21	21	23	24	24	24	27	28	27	26	288	26
DEPRECIATION	117	106	104	107	113	120	119	120	127	132	127	126	1,419	30
RENT	300	265	260	265	282	300	297	299	321	333	322	319	3,563	34
MAINTENANCE	29	7	6	7	7	7	7	7	95	98	95	94	460	6
FEES & PUBLICAT	0	4	4	4	4	5	5	5	7	7	7	7	59	20
ADVERTISING		0	0	0	0	0	0	0	0	0	0	0	0	20
		0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$5,717	$5,537	$5,432	$5,546	$5,900	$6,263	$6,198	$6,253	$7,466	$7,753	$7,491	$7,436	$76,990	
FIXED ASSETS													76,990	
EQUIP - PRIOR	6,495	8,974	8,803	8,988	9,561	10,151	10,044	6,971	3,890	4,039	3,903	3,874	7,141	
EQUIP - CURR	3,139	0	0	0	0	0	0	1,972	2,585	2,684	3,026	3,004	1,367	
EQUIP - FULLY DEP	2,998	2,793	2,739	2,797	2,975	3,159	3,125	3,153	6,959	7,226	6,983	6,931	4,320	
BLDG - PRIOR	1,056	984	965	985	1,048	1,113	1,101	1,111	1,190	1,236	1,194	1,185	1,097	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MONTHLY CENTRAL OFFICE COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.59%	25.92%	16.26%	15.70%	21.52%	100.00%
SALARIES-ADMIN	$0	$2,967	$3,735	$2,344	$2,263	$3,102	$14,410
SALARIES-CLERIC	0	1,985	2,499	1,568	1,514	2,075	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	297	374	234	226	310	1,442
ACCOUNTING	0	(34)	(42)	(26)	(26)	(35)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	69	87	55	53	72	336
TELEPHONE	0	102	128	81	78	107	496
EMPL BENEFITS	0	888	1,118	702	677	928	4,313
PAYROLL TAXES	0	270	340	213	206	282	1,311
TRAVEL	0	70	88	55	53	73	340
IN SERVICE	0	69	87	54	52	72	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	20	26	16	16	21	99
OWNERS COMP	0	174	220	138	133	182	847
INS-PROP,LIAB,WC	0	31	39	24	24	32	150
DEPRECIATION	0	153	193	121	117	160	744
RENT	0	393	495	311	300	411	1,911
MAINTENANCE	0	38	48	30	29	40	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,497	$9,438	$5,922	$5,717	$7,837	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	8,517	10,722	6,727	6,495	8,903	41,365
EQUIP - CURR	0	4,116	5,182	3,251	3,139	4,303	19,992
EQUIP - FULLY DEP	0	3,931	4,949	3,105	2,998	4,109	19,092
BLDG - PRIOR	0	1,385	1,743	1,094	1,056	1,447	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
SALARIES-ADMIN	$0	$2,906	$3,632	$2,380	$2,036	$2,965	$13,919
SALARIES-CLERIC	0	2,011	2,513	1,646	1,409	2,051	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	515	643	421	360	525	$2,464
ACCOUNTING	0	12	15	10	9	12	$58
WORK COMP INS	0	17	21	14	12	18	$82
SUPPLIES	0	109	136	89	76	111	$520
TELEPHONE	0	111	139	91	78	113	$532
EMPL BENEFITS	0	853	1,066	698	597	870	$4,083
PAYROLL TAXES	0	395	493	323	276	403	$1,890
TRAVEL	0	56	69	45	39	57	$266
IN SERVICE	0	119	148	97	83	121	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	55	69	45	38	56	$263
OWNERS COMP	0	172	215	141	121	176	$825
INS-PROP,LIAB,WC	0	30	38	25	21	31	$145
DEPRECIATION	0	152	190	124	106	155	$728
RENT	0	378	473	310	265	386	$1,812
MAINTENANCE	0	9	12	8	7	10	$45
FEES & PUBLIC	0	6	7	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,905	$9,879	$6,472	$5,537	$8,065	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	12,812	16,011	10,489	8,974	13,070	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,987	4,982	3,264	2,793	4,067	19,092
BLDG - PRIOR	0	1,404	1,755	1,150	984	1,433	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
SALARIES-ADMIN	$0	$2,888	$3,705	$2,418	$1,997	$2,911	$13,919
SALARIES-CLERIC	0	1,998	2,563	1,673	1,382	2,014	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	511	656	428	354	515	$2,464
ACCOUNTING	0	12	15	10	8	12	$58
WORK COMP INS	0	17	22	14	12	17	$82
SUPPLIES	0	108	138	90	75	109	$520
TELEPHONE	0	110	142	92	76	111	$532
EMPL BENEFITS	0	847	1,087	709	586	854	$4,083
PAYROLL TAXES	0	392	503	328	271	395	$1,890
TRAVEL	0	55	71	46	38	56	$266
IN SERVICE	0	118	151	99	81	119	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	55	70	46	38	55	$263
OWNERS COMP	0	171	220	143	118	173	$825
INS-PROP,LIAB,WC	0	30	38	25	21	30	$145
DEPRECIATION	0	151	194	126	104	152	$728
RENT	0	376	482	315	260	379	$1,812
MAINTENANCE	0	9	12	8	6	9	$45
FEES & PUBLIC	0	6	8	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,856	$10,076	$6,577	$5,432	$7,918	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	12,732	16,330	10,659	8,803	12,833	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,962	5,081	3,317	2,739	3,993	19,092
BLDG - PRIOR	0	1,395	1,790	1,168	965	1,407	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
SALARIES-ADMIN	$0	$2,700	$3,678	$2,457	$2,039	$3,046	$13,919
SALARIES-CLERIC	0	1,868	2,545	1,700	1,411	2,107	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	478	651	435	361	539	$2,464
ACCOUNTING	0	11	15	10	9	13	$58
WORK COMP INS	0	16	22	15	12	18	$82
SUPPLIES	0	101	137	92	76	114	$520
TELEPHONE	0	103	141	94	78	116	$532
EMPL BENEFITS	0	792	1,079	721	598	893	$4,083
PAYROLL TAXES	0	367	499	334	277	413	$1,890
TRAVEL	0	52	70	47	39	58	$266
IN SERVICE	0	110	150	100	83	124	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	51	70	46	39	58	$263
OWNERS COMP	0	160	218	146	121	181	$825
INS-PROP,LIAB,WC	0	28	38	26	21	32	$145
DEPRECIATION	0	141	192	129	107	159	$728
RENT	0	351	479	320	265	396	$1,812
MAINTENANCE	0	9	12	8	7	10	$45
FEES & PUBLIC	0	6	8	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,343	$10,004	$6,683	$5,546	$8,284	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,900	16,213	10,831	8,988	13,425	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,703	5,045	3,370	2,797	4,177	19,092
BLDG - PRIOR	0	1,304	1,777	1,187	985	1,471	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
SALARIES-ADMIN	$0	$2,630	$3,533	$2,388	$2,169	$3,199	$13,919
SALARIES-CLERIC	0	1,820	2,445	1,652	1,501	2,213	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	466	626	423	384	566	$2,464
ACCOUNTING	0	11	15	10	9	13	$58
WORK COMP INS	0	16	21	14	13	19	$82
SUPPLIES	0	98	132	89	81	120	$520
TELEPHONE	0	100	135	91	83	122	$532
EMPL BENEFITS	0	772	1,037	701	636	938	$4,083
PAYROLL TAXES	0	357	480	324	294	434	$1,890
TRAVEL	0	50	67	46	41	61	$266
IN SERVICE	0	107	144	97	88	130	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	50	67	45	41	60	$263
OWNERS COMP	0	156	209	142	129	190	$825
INS-PROP,LIAB,WC	0	27	37	25	23	33	$145
DEPRECIATION	0	138	185	125	113	167	$728
RENT	0	342	460	311	282	416	$1,812
MAINTENANCE	0	9	11	8	7	10	$45
FEES & PUBLIC	0	5	7	5	4	7	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,154	$9,611	$6,495	$5,900	$8,700	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,594	15,576	10,527	9,561	14,099	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,608	4,847	3,275	2,975	4,387	19,092
BLDG - PRIOR	0	1,271	1,707	1,154	1,048	1,545	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
SALARIES-ADMIN	$0	$2,660	$3,422	$2,410	$2,303	$3,125	$13,919
SALARIES-CLERIC	0	1,841	2,367	1,667	1,593	2,162	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	471	606	427	408	553	$2,464
ACCOUNTING	0	11	14	10	10	13	$58
WORK COMP INS	0	16	20	14	14	18	$82
SUPPLIES	0	99	128	90	86	117	$520
TELEPHONE	0	102	131	92	88	119	$532
EMPL BENEFITS	0	780	1,004	707	676	917	$4,083
PAYROLL TAXES	0	361	465	327	313	424	$1,890
TRAVEL	0	51	65	46	44	60	$266
IN SERVICE	0	108	140	98	94	127	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	50	65	46	44	59	$263
OWNERS COMP	0	158	203	143	136	185	$825
INS-PROP,LIAB,WC	0	28	36	25	24	32	$145
DEPRECIATION	0	139	179	126	120	163	$728
RENT	0	346	445	314	300	407	$1,812
MAINTENANCE	0	9	11	8	7	10	$45
FEES & PUBLIC	0	5	7	5	5	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,236	$9,306	$6,555	$6,263	$8,499	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,727	15,082	10,623	10,151	13,775	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,649	4,693	3,305	3,159	4,286	19,092
BLDG - PRIOR	0	1,285	1,653	1,164	1,113	1,510	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
SALARIES-ADMIN	$0	$2,720	$3,366	$2,479	$2,279	$3,075	$13,919
SALARIES-CLERIC	0	1,882	2,329	1,715	1,577	2,128	9,630
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	482	596	439	403	544	2,464
ACCOUNTING	0	11	14	10	10	13	58
WORK COMP INS	0	16	20	15	13	18	82
SUPPLIES	0	102	126	93	85	115	520
TELEPHONE	0	104	129	95	87	118	532
EMPL BENEFITS	0	798	987	727	668	902	4,083
PAYROLL TAXES	0	369	457	337	309	418	1,890
TRAVEL	0	52	64	47	44	59	266
IN SERVICE	0	111	137	101	93	125	568
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	51	64	47	43	58	263
OWNERS COMP	0	161	199	147	135	182	825
INS-PROP,LIAB,WC	0	28	35	26	24	32	145
DEPRECIATION	0	142	176	130	119	161	728
RENT	0	354	438	323	297	400	1,812
MAINTENANCE	0	9	11	8	7	10	45
FEES & PUBLIC	0	6	7	5	5	6	28
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,400	$9,154	$6,743	$6,198	$8,365	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,992	14,836	10,927	10,044	13,557	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,732	4,616	3,400	3,125	4,218	19,092
BLDG - PRIOR	0	1,314	1,626	1,198	1,101	1,486	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
SALARIES-ADMIN	$0	$2,674	$3,465	$2,387	$2,299	$3,094	$13,919
SALARIES-CLERIC	0	1,850	2,397	1,652	1,591	2,141	9,630
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	473	613	423	407	548	2,464
ACCOUNTING	0	11	14	10	10	13	58
WORK COMP INS	0	16	20	14	14	18	82
SUPPLIES	0	100	130	89	86	116	520
TELEPHONE	0	102	132	91	88	118	532
EMPL BENEFITS	0	785	1,016	700	674	908	4,083
PAYROLL TAXES	0	363	470	324	312	420	1,890
TRAVEL	0	51	66	46	44	59	266
IN SERVICE	0	109	141	97	94	126	568
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	51	66	45	43	58	263
OWNERS COMP	0	159	205	141	136	183	825
INS-PROP,LIAB,WC	0	28	36	25	24	32	145
DEPRECIATION	0	140	181	125	120	162	728
RENT	0	348	451	311	299	403	1,812
MAINTENANCE	0	9	11	8	7	10	45
FEES & PUBLIC	0	5	7	5	5	6	28
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,274	$9,424	$6,493	$6,253	$8,415	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	8,109	10,506	7,239	6,971	9,381	42,207
EQUIP - CURR	0	2,294	2,972	2,047	1,972	2,653	11,938
EQUIP - FULLY DEP	0	3,668	4,753	3,274	3,153	4,244	19,092
BLDG - PRIOR	0	1,292	1,674	1,153	1,111	1,495	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SALARIES-ADMIN	$0	$2,533	$3,216	$2,366	$2,400	$3,044	$13,559
SALARIES-CLERIC	0	1,905	2,419	1,779	1,805	2,289	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	734	931	685	695	881	3,927
ACCOUNTING	0	14	18	14	14	17	78
WORK COMP INS	0	19	24	18	18	23	100
SUPPLIES	0	84	106	78	79	101	449
TELEPHONE	0	106	135	99	101	128	569
EMPL BENEFITS	0	1,103	1,401	1,030	1,045	1,325	5,904
PAYROLL TAXES	0	328	416	306	310	394	1,754
TRAVEL	0	53	68	50	50	64	285
IN SERVICE	0	218	276	203	206	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	23	17	18	22	99
OWNERS COMP	0	158	201	148	150	190	847
INS-PROP,LIAB,WC	0	28	36	26	27	34	150
DEPRECIATION	0	134	170	125	127	161	716
RENT	0	338	430	316	321	407	1,812
MAINTENANCE	0	100	127	93	95	120	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,881	$10,007	$7,360	$7,466	$9,469	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,106	5,214	3,835	3,890	4,934	21,978
EQUIP - CURR	0	2,729	3,465	2,548	2,585	3,278	14,605
EQUIP - FULLY DEP	0	7,346	9,328	6,861	6,959	8,826	39,320
BLDG - PRIOR	0	1,256	1,595	1,173	1,190	1,510	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
SALARIES-ADMIN	$0	$2,548	$3,086	$2,392	$2,492	$3,041	$13,559
SALARIES-CLERIC	0	1,916	2,321	1,799	1,874	2,287	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	738	894	693	722	881	3,927
ACCOUNTING	0	15	18	14	14	17	78
WORK COMP INS	0	19	23	18	18	23	100
SUPPLIES	0	84	102	79	82	101	449
TELEPHONE	0	107	130	100	105	128	569
EMPL BENEFITS	0	1,110	1,344	1,042	1,085	1,324	5,904
PAYROLL TAXES	0	330	399	309	322	393	1,754
TRAVEL	0	54	65	50	52	64	285
IN SERVICE	0	219	265	206	214	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	18	22	99
OWNERS COMP	0	159	193	149	156	190	847
INS-PROP,LIAB,WC	0	28	34	27	28	34	150
DEPRECIATION	0	134	163	126	132	160	716
RENT	0	340	412	320	333	406	1,812
MAINTENANCE	0	100	122	94	98	120	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,928	$9,601	$7,443	$7,753	$9,461	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,130	5,002	3,878	4,039	4,929	21,978
EQUIP - CURR	0	2,745	3,324	2,577	2,684	3,275	14,605
EQUIP - FULLY DEP	0	7,389	8,949	6,937	7,226	8,818	39,320
BLDG - PRIOR	0	1,264	1,530	1,187	1,236	1,508	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
SALARIES-ADMIN	$0	$2,553	$3,116	$2,363	$2,408	$3,118	$13,559
SALARIES-CLERIC	0	1,920	2,343	1,778	1,811	2,345	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	739	902	684	697	903	3,927
ACCOUNTING	0	15	18	14	14	18	78
WORK COMP INS	0	19	23	18	18	23	100
SUPPLIES	0	84	103	78	80	103	449
TELEPHONE	0	107	131	99	101	131	569
EMPL BENEFITS	0	1,112	1,357	1,029	1,048	1,358	5,904
PAYROLL TAXES	0	330	403	306	311	403	1,754
TRAVEL	0	54	66	50	51	66	285
IN SERVICE	0	219	268	203	207	268	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	18	23	99
OWNERS COMP	0	159	195	148	150	195	847
INS-PROP,LIAB,WC	0	28	35	26	27	35	150
DEPRECIATION	0	135	164	125	127	165	716
RENT	0	341	416	316	322	417	1,812
MAINTENANCE	0	101	123	93	95	123	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,944	$9,694	$7,353	$7,491	$9,702	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,139	5,051	3,831	3,903	5,055	21,978
EQUIP - CURR	0	3,209	3,916	2,970	3,026	3,919	17,041
EQUIP - FULLY DEP	0	7,404	9,036	6,854	6,983	9,044	39,320
BLDG - PRIOR	0	1,266	1,545	1,172	1,194	1,547	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
SALARIES-ADMIN	$0	$2,600	$3,195	$2,337	$2,390	$3,038	$13,559
SALARIES-CLERIC	0	1,956	2,403	1,757	1,798	2,285	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	753	925	677	692	880	3,927
ACCOUNTING	0	15	18	13	14	17	78
WORK COMP INS	0	19	24	17	18	22	100
SUPPLIES	0	86	106	77	79	100	449
TELEPHONE	0	109	134	98	100	128	569
EMPL BENEFITS	0	1,132	1,391	1,017	1,041	1,323	5,904
PAYROLL TAXES	0	336	413	302	309	393	1,754
TRAVEL	0	55	67	49	50	64	285
IN SERVICE	0	223	274	201	205	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	17	22	99
OWNERS COMP	0	162	200	146	149	190	847
INS-PROP,LIAB,WC	0	29	35	26	26	34	150
DEPRECIATION	0	137	169	123	126	160	716
RENT	0	347	427	312	319	406	1,812
MAINTENANCE	0	103	126	92	94	120	535
FEES & PUBLIC	0	8	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,090	$9,939	$7,270	$7,436	$9,450	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,215	5,178	3,788	3,874	4,924	21,978
EQUIP - CURR	0	3,268	4,015	2,937	3,004	3,818	17,041
EQUIP - FULLY DEP	0	7,540	9,264	6,776	6,931	8,809	39,320
BLDG - PRIOR	0	1,290	1,584	1,159	1,185	1,507	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED

DAYS 2003	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		1,766	2,534	1,785		1,407	2,244	9,736
FEBRUARY		1,613	2,267	1,630		1,165	2,000	8,675
MARCH		1,782	2,563	1,878		1,263	2,188	9,674
APRIL		1,745	2,414	1,858		1,261	2,113	9,391
MAY		1,733	2,544	1,839		1,305	2,248	9,669
JUNE		1,667	2,359	1,734		1,266	2,110	9,136
JULY		1,746	2,566	1,816		1,281	2,117	9,526
AUGUST		1,752	2,566	1,744		1,428	2,070	9,560
SEPTEM		1,702	2,447	1,627		1,436	2,019	9,231
OCTOBER		1,847	2,601	1,680		1,482	2,237	9,847
NOVEMBER		1,796	2,487	1,604		1,525	2,113	9,525
DECEMBER		2,051	2,582	1,620		1,564	2,144	9,961
TOTAL	0	21,200	29,930	20,815	0	16,383	25,603	113,931
								113,931

OCCUPIED

DAYS 2004	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,030	2,537	1,662		1,422	2,071	9,722
FEBRUARY		1,886	2,419	1,579		1,304	1,901	9,089
MARCH		1,904	2,594	1,733		1,438	2,148	9,817
APRIL		1,814	2,437	1,647		1,496	2,206	9,600
MAY		1,838	2,364	1,665		1,591	2,159	9,617
JUNE		1,847	2,285	1,683		1,547	2,088	9,450
JULY		1,881	2,437	1,679		1,617	2,176	9,790
AUGUST		1,861	2,363	1,738		1,763	2,236	9,961
SEPTEM		1,815	2,198	1,704		1,775	2,166	9,658
OCTOBER		1,897	2,315	1,756		1,789	2,317	10,074
NOVEMBER		1,855	2,279	1,667		1,705	2,167	9,673
DECEMBER		2,013	2,430	1,751		1,652	2,154	10,000
TOTAL	0	22,641	28,658	20,264	0	19,099	25,789	116,451
								116,451

ALLOCATION

PERCENTAGE 2003	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	18.14%	26.03%	18.33%	14.45%	23.05%	100.00%
FEBRUARY	0.00%	18.59%	26.13%	18.79%	13.43%	23.05%	100.00%
MARCH	0.00%	18.42%	26.49%	19.41%	13.06%	22.62%	100.00%
APRIL	0.00%	18.58%	25.71%	19.78%	13.43%	22.50%	100.00%
MAY	0.00%	17.92%	26.31%	19.02%	13.50%	23.25%	100.00%
JUNE	0.00%	18.25%	25.82%	18.98%	13.86%	23.10%	100.00%
JULY	0.00%	18.33%	26.94%	19.06%	13.45%	22.22%	100.00%
AUGUST	0.00%	18.33%	26.84%	18.24%	14.94%	21.65%	100.00%
SEPTEMBER	0.00%	18.44%	26.51%	17.63%	15.56%	21.87%	100.00%
OCTOBER	0.00%	18.76%	26.41%	17.06%	15.05%	22.72%	100.00%
NOVEMBER	0.00%	18.86%	26.11%	16.84%	16.01%	22.18%	100.00%
DECEMBER	0.00%	20.59%	25.92%	16.26%	15.70%	21.52%	100.00%

ALLOCATION

PERCENTAGE 2004	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
FEBRUARY	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
MARCH	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
APRIL	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
MAY	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
JUNE	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
JULY	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
AUGUST	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SEPTEMBER	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
OCTOBER	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
NOVEMBER	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
DECEMBER	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%